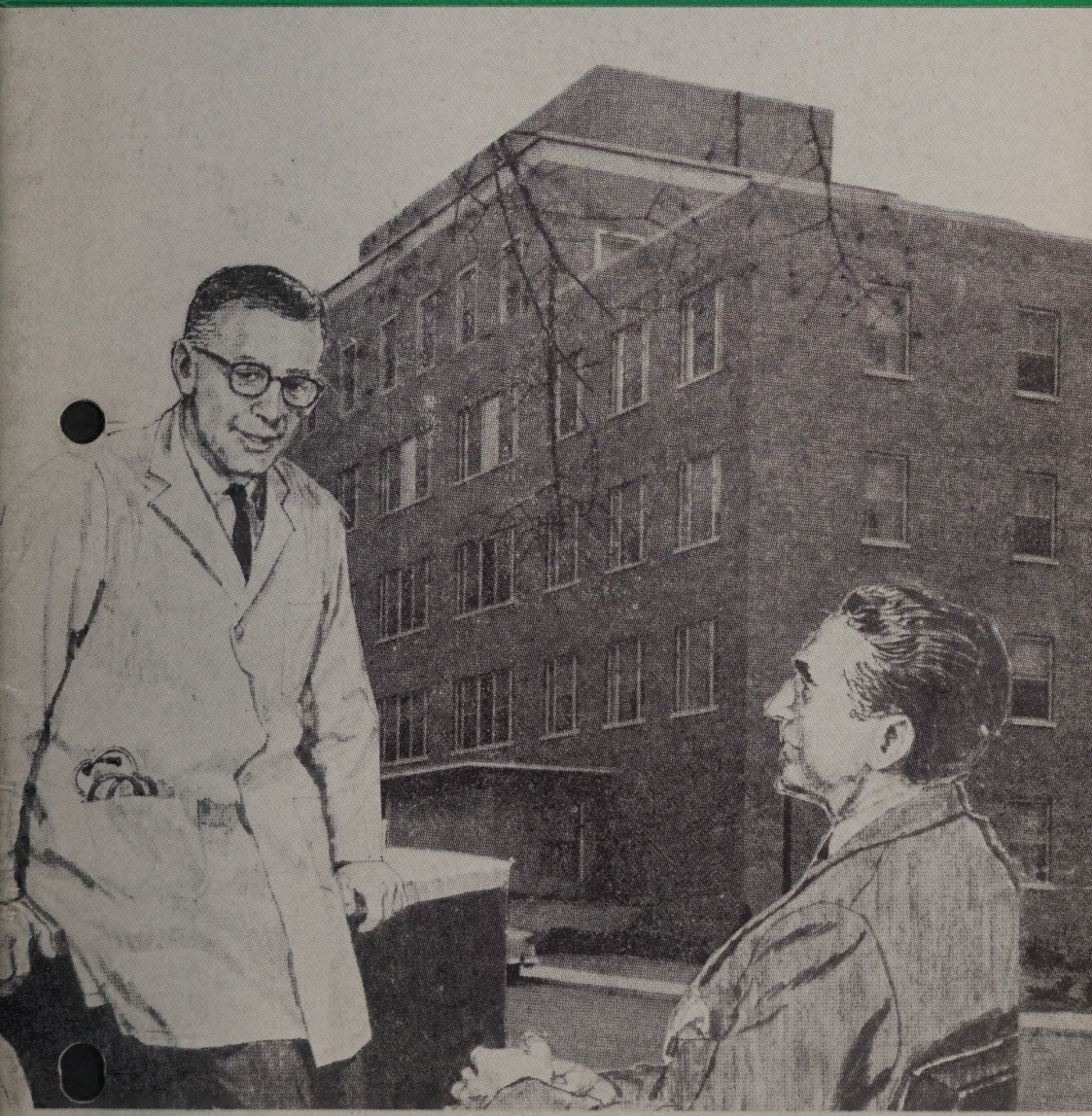
The Hampden Hippocrat

MEMBER MEDICAL SOCIETY MAGAZINE GROUP

A Bulletin for the Hampden District of the Massachusetts Medical Society

VOLUME XX NOVEMBER, 1964 NO. 9



PHYSICIAN - HOSPITAL
RELATIONS

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The Hampden Hippocrat

"Life is short and art is long, the occasion fleeting, experience fallacious and judgment difficult."
Hippocrates

Founded in 1942 by Drs. Edward P. Bagg and William A. R. Chapin, and published monthly except July and August.

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THE HAMPDEN HIPPOCRAT, NOVEMBER, 1964

EDITORIAL

THE PHYSICIAN AND HIS HOSPITAL

Two documents emanating recently from our parent organizations are well deserving of our attention and consideration. Both deal with the all-important subject of physician-hospital relations. The first is the new revision of "Recommended Policies for Hospital-Medical Staff Relationships" which was agreed upon by the combined committees of the MMS and the Massachusetts Hospital Association. This revision, published elsewhere in this issue, was approved by the Council of the MMS at its meeting of October 14, 1964.

The second document is the "Report on Physician-Hospital Relations" approved by the AMA's House of Delegates at the June, 1964 meeting in San Francisco. This report, based on an extensive survey, begins with a reaffirmation of the AMA's 1961 Guides for Physician-Hospital Relations. The document then proceeds to outline some of the current major problems confronting the physician in his relation with the hospital. These problems are

reflected poignantly in the recommendations with which the report concludes (page 20). Of special interest to us as a medical society is the recommendation that " . . . . the state associations and component societies develop means of working with hospital medical staffs to stimulate effective organization and operation."

The disagreements that occasionally arise between staff physicians, hospital administrators and trustees may lead one to suspect that they are all working at cross purposes. But this, of course, is not the case. Usually it is a matter of each not understanding the problems of the other. The need for better understanding was never as urgent as it is at the present time. Factors complicating physician-hospital relations have been steadily on the increase and are bound to multiply as time goes on. One needs but mention the inclusion of medical services in some contracts of voluntary hospital plans; the ever increasing use of hospital emergency departments for non-emergent cases; and the employment of larger and larger numbers of full-time salaried physicians by hospitals. One specific example is the increasing number of salaried directors of education which, as the AMA report points out, are hired by hospitals mostly because medical staffs do not always assume full responsibility for teaching programs. The report adds "The employment by a hospital of full-time physicians to administer teaching programs is in no way to be considered a substitute for active staff participation and direction."

Medical staffs of most hospitals enjoy today the privilege of "self-government." They have their own by-laws, elect their own officers, and appoint their own committees, all designed to achieve high standards of medical care. The quality of such care depends not only upon the professional skills of the physician but also upon the effectiveness of staff organization. Medical leadership stresses that "voluntary controls need continuing rigorous application if the principle of self-government is to be retained."

As time goes on physicians and hospitals are becoming increasingly cognizant of their mutual inter-dependence. They realize also that harmonious relations between the two are indispensable if the best interests of the patient and the public are to be served. To this end we must learn to understand thoroughly the purposes, functions, and problems of each other. To this end, also, the two separate reports of the AMA and of the MMS are as informative as they are timely.

M. M.

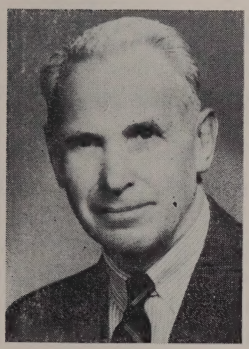
WHAT DO YOU THINK?

This issue of the Hippocrat carries several articles dealing with physician-hospital relations. The authors of these items seem to agree that there is room for improvement. What do you think? Do you agree that physician-hospital relations aren't as satisfactory as they might be? If so, how would you go about improving them?

Jot down your thoughts, comments, and ideas in the form of a letter and mail it to "Dear Hippocrat".

EDITOR

President's Page



FORCES IN P-H RELATIONSHIP

In a discussion of physician-hospital relations there are three components to consider: the governing body of the hospital, the medical staff, and the hospital administrator.

The medical staff must forever remain autonomous, or self-governing. Only physicians can practice medicine. Only the medical staff should make recommendations for appointment to the staff, bearing in mind the moral and professional responsibilities that go with these privileges. If we fail to exercise our prerogatives, somebody else will do it for us.

The governing body has the legal and fiscal responsibilities for the conduct of the hospital as an institution. It must provide the best possible tools for the physician's work. Granting privileges is a grave responsibility. This was brought out in an Ohio State Supreme Court decision which stated that "Where a public, charitable hospital failed to exercise due and reasonable care in the selection of physicians . . . . and injury results from the incompetence or negligence of such persons, the hospital is liable."

The hospital administrator, who is the liaison between the staff and the governing body, is beholden primarily to the latter.

Fortunately, most hospitals have today a mechanism for resolving problems between its three components — the Joint Conference Committee. This should be a continuing committee and not merely a committee of last resort. Adjudication of difficult problems may have to be carried to the M.M.S., the M.H.A. and to the Joint Commission for Accreditation of Hospitals.

Mutual understanding, good will, and a common desire for the good of the health of the community, are the greatest forces toward satisfactory and desirable physician-hospital relationships.

Theodore R. Miner, M. D.

HAMPDEN CAPSULES

Transfers to Hampden:

Dr. Helen Harmand from Essex South. Address: Western Mass. Hospital, Westfield.

Dr. William E. Sheehan from Norfolk. Address: 212 Deepwoods Drive, Longmeadow. Associate in Radiology with Drs. Grugan and Sachsse.

Dr. Ray T. Smith, formerly Secretary of HDMS from non resident. Anesthesiologist at Springfield Hospital.

Dr. H. Elizabeth Cherry's resignation has been accepted by Mass. Medical Society.

Meetings at Headquarters:

Executive Committee
Public Health Committee
Public Relations Committee
Diabetes Detection Committee
Insurance, Labor Relations & Industrial Accidents with Labor Representatives
Medico-Religious Committee

The following councilors attended the October 14th meeting of the Council of the MMS: Drs. Bronos, Franseen, Johnson, LaMarche, Miller, Millman, O'Malley, Palermo, Pokorny, Reilly, and Rini.

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Dr. John Bandeian, Chairman of the Medico-Religious Committee, participated in a panel in Boston, November 5, 1964.

Dr. Alfred N. Aborjaily, Westfield, was inducted on October 8, as a Fellow of the American College of Surgeons.

The 12th Annual White Cap Ball, sponsored by the Auxiliary, was held on November 7 at the Kimball Towers. A complete description of the affair will be published in the next issue of the Hippocrat.

NOW IS THE TIME FOR FLU VACCINATION

Influenza is a serious illness which is likely to be more serious for certain individuals.

The only satisfactory way to prevent or control influenza is vaccination. Today's vaccine is 70% effective in preventing the disease. Because the vaccine takes time to become effective, now is the time to plan this year's program for the vaccination of your patients.

During the flu epidemics from 1958 to 1961, 86,000 deaths occurred. The Surgeon General states that the vaccine might have prevented 60,000 of these extra deaths.

Influenza is especially dangerous for the following groups:

—people suffering from chronic diseases
—pregnant women
—those over 45

You can help control influenza by encouraging your patients to get flu shots, eat the proper foods and get enough rest, especially when they have colds.

Next Hampden District Meeting

TIME: Tuesday, December 1, 1964
6:30 p.m.

PLACE: Kimball Towers
Chestnut Street, Springfield

AGENDA: Business Meeting 6:30 p.m.
followed by
Social Hour
and
Dinner (Courtesy of Society)

SPEAKER: MAURICE A. DONAGHUE, Esq.
State Senator (D)
from 2nd Hampden District

SUBJECT: "MEDICAL LEGISLATIVE PROBLEMS"

YOUR PRESENCE IS URGENTLY REQUESTED

Harry N. Memery, M.D.
Secretary

COUNCIL MEETING HIGHLIGHTS

The Council of the MMS met in the Boston Medical Library on October 14, 1964. The meeting was called to order by President James Marvin Baty at 10:10 a.m.

The minutes of the last meeting, as published in the NEJM, were approved.

Obituary of Dr. Norman Welch, President of the AMA, was read. The sum of $3,000 was voted to a scholarship fund of the AMA to be named in his honor. Replacements for Dr. Welch as a Blue Shield Director and as Assistant Treasurer of the MMS, were announced.

Dr. Toomey of the Lahey Clinic spoke on the "People to People" program as published in the October issue of the Mass. Medical News. According to this program doctors spend their vacations giving short-term help to underdeveloped countries, mostly in Central America.

Reports of Committees on State Legislation, Medical Education, Mental Health, Joint Conference with the Bar, and of the Delegates to the AMA and of the Council of the New England State Medical Societies, were informational and no action was taken.

Recommendations of the Finance Committee that the MMS contribute $3,000 to the AMAERF to be re-allocated without restrictions to the three Mass. medical schools was accepted.

A resolution by Dr. Chapman that the MMS pay the secretary a salary of $25,000 per year was disapproved by the Committee whose recommendation was accepted by the Council.

It was voted also to allow the Norfolk District Society space at the MMS Headquarters on a trial basis for one year.

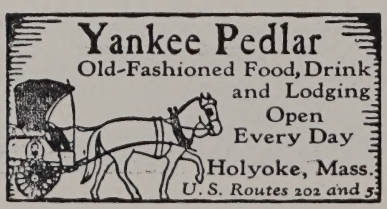
The Committee on Occupational Health showed a disinclination to study the Industrial Accident Board schedule of fees. It was pointed out that this was but one small part of an over all study needed of prevailing fees in other areas. It was so voted.

The By-Laws Committee submitted a number of minor changes to bring the by-laws in accord with prior votes of the Council. These were approved.

The report of the Hospital and Professional Relations Committee was accepted. The policies recommended by this committee are published elsewhere in this issue of the Hippocrat.

A schedule of revised fees to be paid by the Veterans' Administration, submitted by the Committee on Tax Supported Medical Care, was approved. It was pointed out that this was a part of the general picture of prevailing rates and that it would have some effect on setting Industrial Accident and Welfare fees.

The Insurance Committee reported that members holding MMS-sponsored insurance would henceforth be covered on MMS-sponsored charter flights. It reported also that the committee is



COMPLIMENTS

Ernest A. Byron

SPRINGFIELD

currently negotiating with Blue Cross-Blue Shield for improvement in physician's contracts. The Council voted that members of the Committee be provided with a primer annually as to its duties, functions, and privileges.

The report of the Committee to Investigate the Activities of the Committee on Medical Charges and Pooled Funds was the subject of much discussion and some confusion. Finally, its name was changed to that of the Medical Charges Review Committee and it was made a standing committee of the Society. It calls for 6 members with staggered terms. It was recommended that the committee limit itself to cases where the patient, insurance company and physician had been unable to work out a satisfactory solution, and that it might consider also cases of uninsured persons that could not be solved at the local level. It was also voted to appoint an ad hoc Committee to study prevailing fees. A vote of confidence was given the present Pooled Funds Committee.

Under suspension of rules the Society approved a resolution offered by Dr. Curran of Suffolk District that the House of Delegates of the AMA be asked to study the shortage of help, and other problems prevailing at Mental Hospitals, and also to outline factual data relative to the efficiency of the Community Mental Health programs.

Under new business a resolution by Dr. Chapman that the Society contribute $5,000 to the Boston Medical Library was referred to Committee as was also a resolution by Dr. Soutter that the MMS study distribution of physicians in Massachusetts.

The meeting adjourned at 4:15 p.m.

Miller

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BY-LAWS COMMITTEE

The By-Laws Committee recommends the adoption of the amendment published below. This is to be voted on at the next meeting, December 1, 1964. Intalicized sentence indicates proposed changes.

Amendment By Adding to Chapter VII, Section 2 (Grievance Committee)

PURPOSE: To protect the Grievance Committee and the Society against possible entanglement in litigation.

If adopted, this amendment will read as follows:

(e) *Cases where litigation has already been instituted shall not be accepted for consideration.*

Max Millman, M.D.
Chairman

ON TO THE AMA'S

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HOSPITAL - PHYSICIAN RELATIONS

(FROM THE OTHER SIDE OF THE FENCE)

The credo of modern hospital management is "the most effective medical care of patients, by the most efficient means, at the lowest possible cost." This, on the surface seems to be an admirable and praiseworthy goal and mission. However, it forthrightly brings out two principles, namely, standards and economics, both of which are fraught with many complexities and seeds of potential conflict between the hospital (governing body with its agent, the administrator) and the physician (the medical staff).

Standards:

From ample historical and legal precedence, it is the duty of the hospital governing body to operate the facility with due care and diligence for the express purpose of providing the optimum patient care attainable. Elements of this duty include the procurement and operation of the most suitable equipment that the hospital can afford, the employment and supervision of competent personnel, and the selection and general supervision of a competent medical staff. In the latter instance, hospital governing bodies have been dealt an extremely sensitive responsibility - the evaluation and the improvement of the quality of medical care. No longer are medical standards a matter of an individual practitioner's conscience with staff privileges taken for granted. Rather it is a true partnership between the governing body and the organized medical staff to whom the former can confidently delegate the supervision and maintenance of high quality medical care.

The conflicts that arise between hospital governing bodies and their medical staffs are partially due to disunity among staff physicians. It is maintained that some physicians, realizing the authority of the governing body "try to use the latter as a 'cat's paw' to achieve their ends and as a shield when the inevitable retaliation comes from their colleagues who have been adversely affected by the actions of the trustees." Cases in point are the alleged conflicts between general practitioners and specialists, between certified and noncertified specialists, between "town" and "gown" physicians, between clinic and solo practitioners, and between closed panel and private practitioners. Moreover, there are such jurisdictional disputes as between surgeons and gynecologists, plastic surgeons and otolaryngologists and oral surgeons, clinical hematologists and pathologists, etc. There are also those conflicts which gerontocracy generates.

With the aforesaid in mind, is it any wonder that a governing body may become ornery on occasion when it is caught in a "damned if you do and damned if you don't" position. Legislative, judicial, administrative, and special-interest groups are questioning the efficacy of voluntary controls of

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hospitals and medical care. Even the House of Delegates of the A.M.A. recently had to admit that the voluntary controls as contained in the system of medical staff "self government" are not being uniformly and effectively applied. As a result, the House of Delegates has recommended that "state associations and component societies develop means of working with hospital medical staffs to stimulate effective organization and operation."

Hospital governing bodies are deeply concerned with business, maintenance, housekeeping, and ever present financial puzzles. This preoccupation with items other than medical care can be deliberate, but for the most part, it is an unconscious evasion of a trouble spot by a group that is already overcommitted. However, because of external pressures, governing bodies can no longer play the "ostrich game" with quality of medical care. This does not mean that they should meddle in, or interfere with the privileged patient-physician relationship or the physician's free and complete exercise of his medical judgment and skill. However, they can develop the "art of critical judgment" on a broad policy level with the help of an effectively organized and functioning medical staff.

Economic Aspects:

Advances in medical science and technology, the subdivision of knowledge and skills among physicians and paramedical personnel, research and educational programs, and the dramatic growth of health insurance and prepayment plans, all have increased the demands on hospitals and have also fostered greater interdependency between physicians and hospitals. It is no secret that hospital costs have just about quadrupled in the past 20 years with professional costs rising close to 400% as compared to "hotel-type" costs which have risen to a little over 50%. Physicians are responsible for much of a hospital's income but they are also responsible for much of its expense.

Not always are needs being entirely separated from desires. For instance, must every hospital be expected to have available facilities for every new diagnostic or therapeutic procedure? Must there be so much reliance placed on laboratory and radiological procedures? Must every hospital be an elaborate educational center for the convenience of the medical staff but paid for by the patient?

Organized medicine has always opposed every act which permits the physician's services to be exploited for the financial profit of any agency. This stand is admirable, but it is loaded with many complexities. Governing bodies that enter into the corporate practice of medicine with the sole

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intent of deriving a profit, should justifiably be criticized and condemned for not serving the best interests of the patient. However, there is much to be debated in the instance where hospitals are said to be resisting the transfer of insurance coverage for professional services from hospitalization contracts (i.e. Blue Cross) to contracts for professional services (i.e. Blue Shield) because they realize "profits" from such professional services reimbursements which they use to offset other costs of hospital service. Perhaps, this is a sloppy way of doing business and charges should be brought in line on the basis of strict cost accounting. But, would this not, perhaps, bring about a situation wherein the cost for some essential hospital or professional service would be so prohibitive that it would have to be dropped or not made available? But again, this too might be beneficial if it led to more practical and efficient use of highly specialized but expensive professional services on a planned cooperative community basis.

Discussion:

The time has come when both hospital governing bodies and their respective medical staffs must realize that high quality medical care is not only dependent on the effective organization and functioning of the medical staff but also on the excellence of hospital management. Moreover, the excellence of hospital management is not solely the responsibility of the governing body. Both must be concerned with it and both must share the responsibility for the quality and efficacy of the total management of the hospital. There must be joint planning with full acceptance of compromise, coordination, integration, and elimination of waste. This may be a bitter pill to swallow for some physicians who by their very training and background tend to resist any infringement on what they deem to be their "sacred rights." However, both governing bodies and their respective medical staffs must work together with candor and statesmanship to resolve problems internally. Medical and hospital associations must provide mechanisms whereby unbiased advice can be provided in helping to resolve problems which cannot be solved internally. Moreover, governing bodies and their respective medical staffs must plan and operate on a more cosmopolitan basis than just their own selfish interests or they may price the "voluntary way" out of existence. More than ever, the public must be convinced that the "best medical care at the lowest possible cost" is being fairly and effectively provided in the public interest by our hospital management team (this includes each respective medical staff). Otherwise, third party regulation and control - be it governmental or special interest group - is inevitable.

John C. Ayres, M.D., Administrator
Springfield Municipal Hospital

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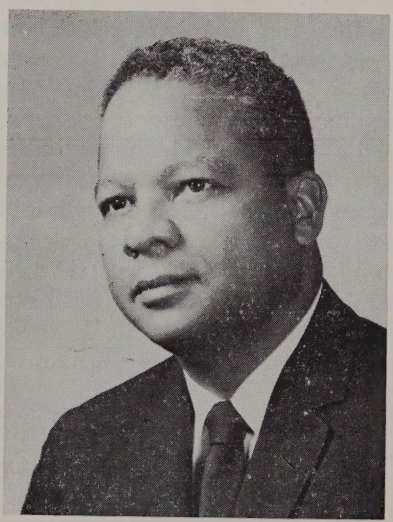
Anything on your mind? Share it with the Hippocrat.

ACADEMY

The next meeting of the
SPRINGFIELD ACADEMY OF MEDICINE
will be held on
TUESDAY, DECEMBER 8, 8:30 P.M.

Speaker:	CARROLL M. LEEVY, M. D. Professor of Medicine and Director Division of Liver and Nutrition Seton Hall College of Medicine
Topic:	"MEDICAL & SURGICAL TREATMENT of LIVER FAILURE"
Place:	Auditorium, Municipal Hospital, Springfield
Hospital Clinic:	Wesson Memorial Hospital, 5:00 P.M.



Carroll M. Leevy, M. D.

Drs. Jerome Whitney and Eugene Boss, Jr., chairmen of Mental Health Committees of the M.M.S. and the H.D.M.S. respectively, attended recently the A.M.A.'s National Congress on Mental Health.

Removal of Office:

To 39 Mulberry St., Springfield
Bernard Bloom, M. D.
Leon Kruger, M. D.
Howard Crawford, M. D.
Arthur Pava, M. D.

NEXT DISTRICT MEETING, DECEMBER 1st (See Page 5.)

IN MEMORIAM

SAMUEL R. FELDMAN, M. D.

Dr. Samuel R. Feldman of 82 Wayne St., Springfield, died at the Springfield Hospital on October 3, 1964.

Born in Hartford on April 23, 1903, he was educated in the Springfield schools and graduated from Colby College in 1926. After receiving his M.D. from the Boston University School of Medicine in 1931, Dr. Feldman interned at the Mass. Memorial Hospitals in Boston. Thereupon, he came to Springfield in 1932 to enter into the private practice of medicine. Following World War II, Dr. Feldman completed a surgical residency at the U. S. Navy Hospital, Chelsea, Mass. in 1952 and returned to Springfield entering into the practice of general surgery.

Dr. Feldman served on the surgical staff of the Springfield Hospital. He was a member of the American Medical Association, the American College of Surgeons, the Mass. Medical Society, the Hampden District Medical Society, and the Springfield Academy of Medicine. During World War II, Dr. Feldman served in the Medical Corps of the U. S. Navy as Captain and remained an active reserve officer until the time of his death.

Deepest sympathy is extended to the surviving members of his family and to his many friends and associates.

COMING EVENTS

HAMPDEN DISTRICT MEETING, DECEMBER 1, 1964 (Page 5)

EXECUTIVE COMMITTEE MEETINGS: NOVEMBER 17 and DECEMBER 15

ACADEMY MEETING, DECEMBER 8 (Page 12)

DIABETES DETECTION WEEK, NOVEMBER 15 - 21

A.M.A. CLINICAL MEETING, MIAMI BEACH, NOVEMBER 29 - DECEMBER 2

M.M.S. COUNCIL MEETING, FEBRUARY 10, 1965

M.M.S. ANNUAL MEETING, BOSTON, MAY 18, 19, and 20, 1965

A.M.A. ANNUAL MEETING, SAN FRANCISCO, CAL., JUNE 21 - 25

A
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OF

PREVENTION

Most viruses remain untouched by today's antibiotic agents. Once a virus infection has become entrenched, treatment can only be supportive or palliative, and recovery is often slow. To date, the most fruitful means of attacking viruses is by prevention through immunization. Immunizing agents are now available to thwart many of the killers of yesterday. Intensive research in immunology moves toward the conquest of many other viruses—those that kill as well as those that slow us down.

Pfizer's work in the field of immunology is modern and expanding. For all practical purposes, it was launched in 1958 with the licensing by the National Institutes of Health of a monovalent Asian influenza vaccine. Later in the year, influenza polyvalent vaccine, types A and B, containing four virus strains was licensed and marketed. Two new strains were added in 1963, on the recommendation of the U.S.P.H.S.

In 1959, Pfizer introduced an improved high-potency Salk polio vaccine and rapidly became one of the largest suppliers of this material.

Company virologists, meanwhile, had been working with Dr. Sabin on oral polio vaccine. By the end of 1961, Types I and II had been licensed and they were followed by Type III early in 1962.

Research on a measles vaccine had also been in progress, based on the achievement of John Enders and his associates in isolating the virus and in developing the original tissue culture methods needed to grow the virus in quantity. Four years of intensive research bore fruit in March 1963, with the licensing of a killed-virus mea-

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sles vaccine. Behind it were two years of clinical testing on more than 17,000 children in nearly 100 cities.

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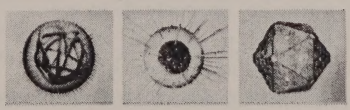

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RECOMMENDED POLICIES FOR HOSPITAL-MEDICAL STAFF RELATIONSHIPS*

As Approved by the Council of the MMS, October 14, 1964*

Recognizing that physicians and hospitals are mutually interdependent, and believing that the best interests of the public are served by the preservation of harmonious relations between physicians and hospitals, the Massachusetts Medical Society and the Massachusetts Hospital Association have agreed upon the following principles.

The governing body of the hospital is the ultimate authority in all management of the affairs of the hospital, but since the governing body is not competent in medical matters, it delegates authority for the conduct of the medical functions of the hospital to the medical staff. The traditional practice of annual appointments was adopted to make the medical staff accountable to the governing body, and in general, the same procedure for reappointments should be followed as for new appointments.

Appointment to Hospital Medical Staff

Appointment of physicians to the medical staff of any hospital shall be in accordance with applicable provisions of the bylaws of that hospital. All physicians in all branches and specialties of medicine shall be treated similarly. Certain broad principles apply, and shall be in accord with the Joint Commission on Accreditation of Hospitals' "Standards for Hospital Accreditation," dated April 19, 1953.

1. Applicant must be properly licensed and a graduate of a medical school acceptable under the bylaws of the medical staff and governing body.
2. Membership in the Massachusetts Medical Society is desirable and may be required.
3. Formal application should be referred to the appropriate Chief of Service, or to the Chief of Staff, who shall refer the application to the Credentials Committee of the Staff.
4. The Credentials Committee shall make recommendation to the voting staff or to the governing body as provided in the staff bylaws.
5. The Governing Body of the hospital shall receive notice of the action of the Staff and/or the Credentials Committee and make final decision concerning appointment of the applicant as a member of the Staff. The legal power and responsibility for appointments and reappointments to the medical staff lie in the governing body of the hospital.

Revocation or Restriction of Hospital-Medical Staff Apointment

Since the Joint Commission on Accreditation of Hospitals does not outline the procedure to be followed for revocation of staff appointments, the following procedure is recommended:

1. Formal proceedings to revoke hospital staff membership, to change staff privileges, or not to reappoint may be initiated by the staff, a chief of service, or by the governing body, and shall be referred to the proper staff committee (Credentials Committee). This committee in accordance with existing by-laws shall report to the voting staff or to the appropriate

* Revision of "Blue Book", in operation since 1954.

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staff body who shall make a recommendation to the governing body of the hospital.

2. Decision to revoke staff membership, restrict privileges, or not to reappoint shall be made only by the governing body and written notification shall be sent promptly to the physician. In no case shall the governing body take such action without prior consideration by the staff or the appropriate staff body as outlined above, and in accordance with any applicable provisions of the bylaws of the medical staff of the individual hospital.
3. A physician shall be acquainted with the charges against him and be granted an opportunity to speak in his own behalf before the appropriate committee of the staff, the entire staff, and the governing body.
4. Under certain conditions when desirable for the protection of the physician or the hospital, a staff member may be offered the option of resigning.
5. Should the staff member involved or the staff be unwilling to accept the decision of the governing body, request for a review must be made in writing to the administrator of the hospital or the governing body within thirty days of receipt of written notice of the action of the governing body.
6. A hospital committee with equal representation from the staff and governing body shall be formed to review the case and send its recommendations to the governing body with a copy to the staff or appropriate staff body and to the involved member or members within sixty days.
7. If this hospital committee is unable to reach a decision or if any of the parties involved remains dissatisfied, the matter may be referred to the president of the Massachusetts Medical Society and/or to the president of the Massachusetts Hospital Association, who shall refer the problem to an appropriate committee of his respective organization, or to a joint meeting of the two above committees if the presidents deem it expedient.
8. If the above committee or committees cannot arrive at a solution satisfactory to the involved parties, the dispute shall be again referred to the presidents of the Massachusetts Medical Society and Massachusetts Hospital Association, who shall appoint an ultimate appeal board, composed of six members; three physicians appointed by the president of the Massachusetts Medical Society and one hospital administrator and two trustees appointed by the president of the Massachusetts Hospital Association. None shall be from the hospital under discussion. The six appointed members of this committee shall meet and select an additional lay member, not a hospital trustee or administrator, to serve as chairman.
9. The report of this committee shall be sent to the governing body of the hospital, to the hospital staff, or appropriate staff body, and to the involved member or members of staff, and to the presidents of the Massachu-

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setts Medical Society and the Massachusetts Hospital Association.

10. The report of this committee shall be made available to the Joint Commission on Accreditation of Hospitals on its request.

Grievance Procedure

1. A standing committee of the Massachusetts Medical Society shall act as a board to hear from a physician any charge of exploitation or any grievance pertaining to hospital professional relations other than those outlined under "revocation or restriction of hospital-medical staff appointment." The Committee on Hospital and Professional Relations may be considered such a committee.
2. A standing committee of the Massachusetts Hospital Association shall act as a board to hear from a hospital any charge of exploitation or any grievance on matters pertaining to professional relations with physicians, other than those outlined under "revocation or restriction of hospital-medical staff appointment." The Council on Professional Practice may be considered such a committee.
3. If a member of a hospital staff or the medical staff itself has a grievance against the hospital, the aggrieved physician or the staff shall first attempt to obtain adjustment of the situation within the institution through the administrator, the medical staff and its appropriate bodies and the governing body. Failing in this, the aggrieved physician or medical staff shall be free to present the case before the appropriate standing committee of the Massachusetts Medical Society without prejudice to his or its position in the hospital.
4. If the administrator or governing body of any hospital has a grievance against a staff member or against the medical staff, the aggrieved administrator or governing body shall first attempt to obtain adjustment of the situation within the institution through the administrator, the medical staff and its appropriate bodies and the governing body. Failing in this, the aggrieved administrator or governing body shall be free to present the case before the appropriate standing committee of the Massachusetts Hospital Association without prejudice to his or its position in the hospital.

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Remuneration of Physicians

The Massachusetts Medical Society and the Massachusetts Hospital Association agree that the manner of remuneration of physicians for their professional services in all branches and specialties of medicine by a hospital is an individual matter and shall be left to each hospital and physician for agreement. Such agreement shall satisfy the following conditions:

a. The financial arrangement, if any between a hospital and a physician shall be under terms or conditions which do not permit exploitation of the patient, the hospital or the physician.

b. In the care of private patients, the collection of fees for professional services shall be the responsibility of the physician rendering such services. If mutually agreeable, collection may be made by the hospital on behalf of the physician, providing the physician's services are identified to the patient as such. The amount paid to or retained by the hospital for space, equipment, and other expenses related to the department used by the physician(s) is an individual matter to be agreed upon by the physician(s) and the hospital.

c. Hospitals, medical schools, foundations and other lay or professional bodies may properly remunerate physicians for such services as administration, teaching, research, and the care of patients for whom no professional fee is charged or collected.

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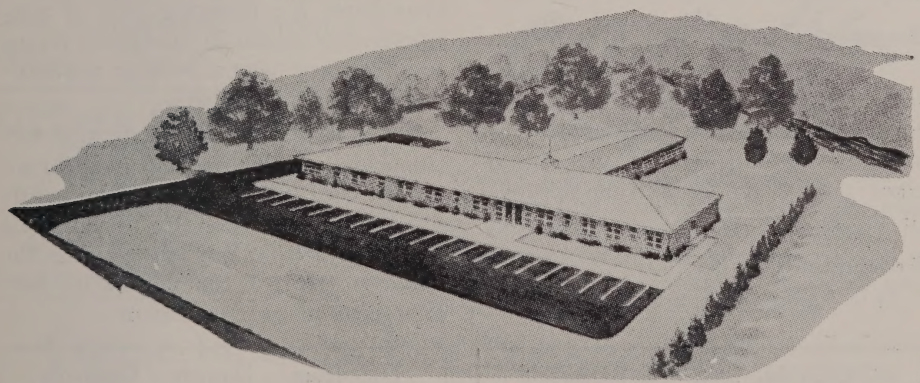

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AMA's RECOMMENDATIONS for HOSPITAL-MEDICAL STAFF RELATIONS

Recommendation A-1

In the light of the fact that some medical staffs are not functioning properly, and inasmuch as it is the obligation and responsibility of the medical profession to insure high quality of care in the hospital, it is recommended that the state associations and component societies develop means of working with hospital medical staffs to stimulate effective organization and operation.

Recommendation A-2

Because quality of care is also dependent on the quality and efficacy of the total management of the hospital, it is recommended that medical staffs be considered an integral part of the administrative team of the hospital.

Recommendation B-1

It is therefore recommended that a medical staff not approve any plan to institute a teaching program unless it is willing to accept in full measure the responsibilities thereof.

Recommendation B-2

It is also recommended that in those instances where employment of full-time staff physicians is deemed necessary, the employment of such physicians should be only with the approval of the medical staff.

Recommendation B-3

It is further recommended that such employment shall be consistent with the Principles of Medical Ethics and with other policies of the American Medical Association.

Recommendation C-1

It is recommended that it be the policy of the American Medical Association that a hospital governing authority, administrator or other third party should not bargain, enter into a contract, or offer for sale or sell the professional services of a staff physician. The physician and the medical staff, as principals, should not approve any contract whose terms or conditions are inconsistent with the "Principles of Medical Ethics" and with established policy of the American Medical Association.

HOSPITAL EMERGENCY DEPARTMENTS

Recommendation E-1. It is therefore recommended that physicians be reminded that they have been partially responsible for fostering care of non-emergent problems in emergency rooms and that they have a 24-hour responsibility to their patients.

Recommendation E-2. It is also recommended that component medical societies work with the medical staffs and administrative staffs of hospitals in their jurisdictions to educate the public to the true function of the hospital emergency department.

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Recommendation E-3. It is further recommended that the following be considered as acceptable means for staffing hospital emergency departments when it is impossible to provide staffing through voluntary arrangements and it is necessary to employ physicians to provide services:

a. The employment by the hospital on a salary basis of one or more licensed physicians under terms or conditions approved by the medical staff which are consistent with the Principles of Medical Ethics and other policies of the American Medical Association.

b. The employment of licensed physicians by a medical partnership or corporation, approved by the medical staff, and composed of all or part of the members of the medical staff, with billing and remuneration for such professional services to be on any mutually satisfactory arrangement between the medical partnership or corporation and may obtain such payments.

Recommendation E-4. Recognizing that these mechanisms do not by any means cover the whole gamut of possibilities for staffing of hospital emergency departments, it is recommended that there be continuing exploration in this field.

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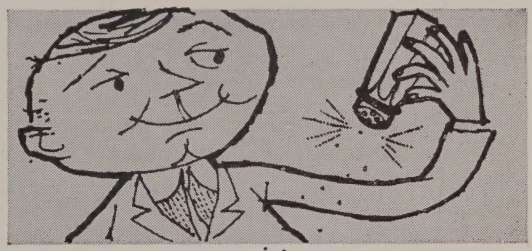

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CORRESPONDENCE

Immunization Information

Dear Hippocrat:

The following information was received recently from the Mass. Department of Public Health. Because physicians telephone frequently for immunization guidance this information should prove helpful.

Lowell Bellin, M.D., M.P.H.
Commissioner of Public Health
Springfield

General Recommendations

1. DPT, DT, or TD - oral polio vaccine - smallpox vaccination may be given on the same day in the absence of specific contra-indications.
2. It is not necessary to repeat an injection or to "start over" on a series.
3. Patients who have had the basic series of Tetanus Toxoid (such as veterans) require only a booster of TD. Regarding diphtheria widespread experience indicates that most adults carry a small natural level of diphtheria antibodies which will be raised to a higher titre with a single booster.
4. Routine tetanus immunization should be given at 4-5 year intervals up to adulthood, every 10 years thereafter.
5. Frequency of smallpox vaccination:- before the first birthday, revaccinate on school entry, and every 3 years for high risk people (medical, airport, or seaport personnel). The Department does not specifically recommend routine periodic revaccination except as a matter of individual decision to be handled by the family physician.
6. The polio immunization of infants during the first year of life and routine re-immunization on entering school is strongly recommended. The oral vaccination of persons over 18 should generally be recommended only in those situations in which unusual exposure to poliomyelitis might be anticipated, such as epidemics, entry into military service, and travel to other countries.

Contraindications to Immunization in Mass Clinics

1. Acute illness or infection.
   e.g. Upper respiratory infection, cold, fever, cough, rash, upset stomach, diarrhea.
2. Pregnancy. Patient should be referred to own physician, who may consider TD, OPY, or IPV vaccine immunization satisfactory in all trimesters of pregnancy.
3. Some medications.
   a. Patients receiving cortical steroids may have a reduced immunological response. A week should elapse following termination of steroid ther-

apy.

b. Such drugs as insulin, tranquilizers, digitalis are not considered contraindications.

4. Chronic serious illness.

   e.g. Leukemia, generalized cancer, Hodgkin's Disease, collagen diseases, rheumatic heart disease, severe allergies (patients with a history of allergy, but symptom-free at present, may be given DPT, DT, TD, or OPV).

5. Previous severe reactions to injections should be investigated. Dosage of immunizations may be reduced or divided over a period of time to avoid serious reactions.

6. Infants or children with a history of cerebral damage or of convulsions with fever should not receive pertussis immunization since a reaction to the vaccine may be encephalitis. The same is true of smallpox.

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TEACHING DAY AT WESSON MATERNITY

Wednesday, November 18, 1964

John Van S. Maeck, M.D., Professor and Head of Department of Obstetrics and Gynecology, University of Vermont, Burlington, Vermont.

10 A.M. - 11 A.M.

Ward Rounds:

Malcolm S. Allan, M.D.
Chief of Staff
John Van S. Maeck, M.D.
Obstetrician in Chief pro tem

11 A.M. - Noon

"Can the Mid-Forceps operation be eliminated?"

John Van S. Maeck, M.D.

Noon - 1 P.M.

Luncheon - Wesson Maternity Hospital

1 - 2 P.M.

Case Presentations:

Jules Hollander, M.D.
Resident-Department of Obstetrics-Gynecology.

2 - 3 P.M.

"Management of Obstetrical Emergencies."

John Van S. Maeck, M.D.

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Auditorium, Springfield Hospital

5:00 P.M. Clinical Sessions
6:00 P.M. Pediatric Rounds
6:30 P.M. Dinner
8:00 P.M. Lecture by Frank G. De Luca, M.D.
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Rhode Island Hospital
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Subject:

"Surgical Emergencies in the Newborn".

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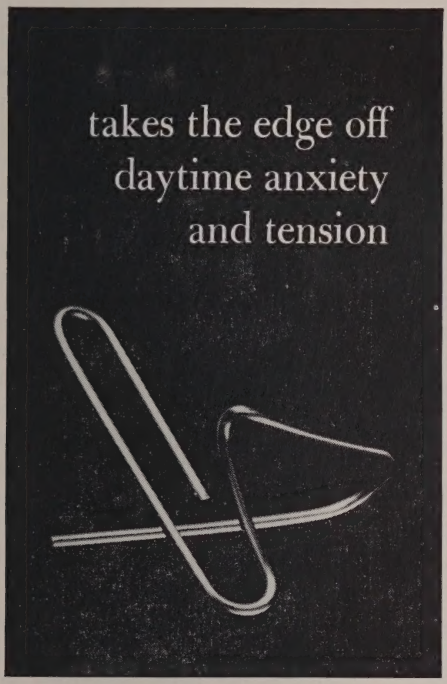

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AMA P-H Report

FROM AMA REPORT

(More on page 20)

"It is desirable that means should be provided at local, state, and national levels for review of problems of individual hospital-physician relationship by organized medical and hospital groups.

"The general purpose of hospitals and physicians is to aid each other in the delivery of the best possible medical care to patients. To attain such a purpose requires full cooperation among medical staffs, governing boards and administrative heads of hospitals. One important method of attaining this objective is that duly designated representatives of the medical staff shall have free and direct access to the governing board with due consideration to the position of the administrator as chief executive officer of the hospital. The various methods by which the medical staff may have access to the hospital governing board follow.

These methods are not listed in the order of their desirability, and there may be other acceptable liaison plans developed depending on local conditions.

"The professional evaluation of chiefs of service and members of the medical staff should be the responsibility of the medical profession. The method of selection of these individuals must be subject to local arrangement and local conditions. In any such arrangement, however, the principle of the freedom of the staff to make recommendations, subject to the approval of the hospital governing board, should be recognized.

"The medical profession and the hospitals recognize that certain special services, such as, anesthesiology, pathology, radiology, and physical medicine are integral parts of the practice of medicine and of the services necessary for hospital patients. Physicians in these fields should have the professional status of other members of the medical staff. Chiefs in these specialties must assume also the administrative responsibilities and relationships customarily associated with such positions."

QUOTE OF NOTE

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Dean George P. Berry
Harvard Medical School

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